Virginia Department of Behavioral Health & Developmental Services

2nd Statewide Refugee Mental Health Summit
Hilton Hotel Short Pump, Richmond, Virginia
Tuesday, July 28, 2015

Summary Report

Purpose

The purpose of the 2nd Statewide Refugee Mental Health Summit is to provide opportunity for agency executives, behavioral health providers, direct mental health service workers, and refugee leaders to network and help develop plans to eliminate barriers to mental health care through integrated and collaborative efforts. This year's gathering hopes to:

- Gather information on local and regional best practices, successful collaborative efforts, and promising practices that can help address barriers in mental health care
- Gather policy and program recommendations to expand the number of providers prepared to serve refugees in the public and private sector
- Create a venue for networking and collaboration across the Commonwealth related to refugee mental wellness and capacity building measures.

Background

The Virginia Refugee Healing Partnership is a collaborative effort of the Virginia Department of Behavioral Health and Developmental Services, the Virginia Department of Health, multiple community agencies, and refugee communities across the Commonwealth. The partnership designs and disseminates programs and activities that:

- Promote positive mental health and cultural adjustment in the refugee community
- Create linkages between provider communities and the refugee communities
- Provide opportunities for trauma-informed education at the community level and culture-informed education at the provider level.

To carry out sustainable initiatives at the local levels, various refugee mental health councils and/or refugee mental health referral systems are developed across the state. This statewide summit is recognition of the hard work and dedication of all council members and/or refugee mental health referral systems support partners who keep the wheel of change moving. It serves as a forum to discuss current issues, a collaborative undertaking to solve issues related to refugee mental health care, as well as a professional and educational advancement opportunity.

Four (4) focus group sessions were simultaneously held for agency executives, direct support professionals, behavioral health providers, and refugee community leaders. This lead to the identification of six (6) major barriers to wellness: 1) Interpreter Services, 2) Access to Care, 3) Advancement Opportunities, 4) Community Resources, 5. Mental Health Prevention and 6) Information Dissemination.

1. Interpreter Services

In compliance to Title V1 of the Civil Rights Act, interpreter services is very important so that a limited English proficient refugee clients can effectively communicate with their provider and understand the issues about their conditions just as an English-speaking clients would have communicated and understood. The success of the healing process highly depends on effective communication bridged by certified medical interpreters.

To help solve the problem, the following were recommended:

- Utilize more language lines, identify mental health providers who have certain language capacities, or use interpretation services.
- Offer more classes/training for certified mental health interpreters to increase interpreter pool.

2. ACCESS TO CARE

Access to mental health care can be attributed to: 1) providers, 2) refugee clients, and 3) the system.

Providers. The barriers identified include:

- the number of available providers willing to take Medicaid;
- providers willing to provide interpretation services, per Title V1 of the Civil Rights Act;
- willingness of providers to take and treat clients using interpreter services (face to face, language line, or other means);
- providers who may not understand how to incorporate foreign cultural values and behaviors into the Western approach to mental health treatment process.

To address this, the focus group recommends that:

- a directory of providers willing to provide services be made,
- host conferences/roundtables for MH providers to discuss solutions, gather program recommendations for expanding the number of providers who are culturally informed;
- work with providers directly servicing clients in medical homes,
- and engage providers, i.e. via media snip

Refugee Clients For healing to take place, the client must have the desire to get healed. Providers cannot do much without the willingness and cooperation of the refugee clients to seek treatment, comply with the care plan, and get healed. Issues with clients include: not keeping with appointment, non-compliance to treatment/care plan, difficulty navigating the Virginia mental health system, Medicaid issues, limited support system, conflict with practices and belief systems from their home country and the western approach, stigma, financial considerations (transportation, medicine, absent from work, etc), etc. The focus group recommends: include mental health in overall refugee orientation, offer training skills for refugees to navigate the Virginia mental health system, provide orientation about cultural considerations for mental health treatment in the United States, provide community-based mental health orientation to decrease stigma and increase willingness to seek treatment, conduct questionnaire survey to identify current needs of refugees (i.e. housing, socialization, mental health prevention activities, etc) that can be triggers to mental health issues. The issue with gaps in Medicaid can be addressed through policy recommendations and tapping into the "indigent funds" of hospitals, clinics, etc. Adult learning center, schools and refugee office on ESL

The focus group recommend including mental health in overall refugee orientation; offering training for refugees to help navigate the Virginia mental health system; provide orientation about cultural considerations for mental health treatment in the United States; provide community-based mental health orientation to decrease stigma and increase willingness to seek treatment; conduct surveys to identify current refugee stressors that can be triggers to mental health issues

The System Gaps in Medicaid was the most pressing issue identified as barrier to wellness. The other barrier is voluntary refugee mental health screening. Treatment can be an option, but it is important that the refugee knows about the nature of trauma, what could be the risk factors, and what to do when mental health issues arise. The group recommended a statewide effort for wellness program expansion by making the mental health screenings part of the mandatory health screenings; strengthening and expanding the mental health councils, developing program for integrated health and mental health services; and bringing service to the community and not expecting people "to come to us".

3. Advancement Opportunities

Advancement opportunity is essential for. Advancement opportunities can be professional or educational. Providers and executives identified gaps in the following resources: cultural orientation tools for providers (CAL info sheets, updated resources, etc) and cross-cultural communication, cross cultural efficacy, integrated care, cultural assimilation/integration, and cultural and language barriers training about both adults and youth refugees.

To meet these challenges, the focus groups recommended expanding opportunities for such learning within professional organizations activities and requirements (i.e. RNs psych counseling requirements, policy projects, etc); indentify schools (community college, universities, etc) that can support community integration courses including MH and psycho-education; facilitate the use of free resources (STEP Program, STAR training, SAMSHA, etc); offer webinars that count towards licensure; offer cultural and linguistic competence training, and expand the Mental Health ESL Module for refugees. Other sessions should be available to discuss publicly/openly issues around gender, shame, respect for cultural norms, fear, and suicides in prisons (high risk) for law enforcement and other ancillary support services.

4. Community Resources

Community resources for refugee mental health and wellness in each region vary but all have public, private, and non-profit organizations whose mission is to help the community grow and develop. The barriers identified include: leadership in the refugee community, disconnect with school/universities in the area, lack of awareness in the community setting, and inadequate collaboration efforts with community groups (volunteer organizations, non-profit groups, interest groups). The focus groups have the following input related to community resources:

- Be more community based, tap on existing resources (Promontores de Salud, domestic violence agencies, United Way, YMCA, etc), peer support, and train for "navigators";
- understand that agencies have the opportunity to ID community leaders and invite them to provide input re: policies, etc and bring groups together;
- build coalitions with multiple groups. For example, universities can help with community assessments and data analysis;
- partner with hospitals, local public health, health community councils;
- reach out to faith-based communities for funds, involvement, awareness;
- reach out to community Advocates where there are peers to refugee youth;
- connect with university counseling centers/health centers to encourage stigma/educational opportunities/integration;
- utilizing college and universities for internships who can reach out to high schools;
- utilize community health workers as support partners;
- look for other resources that could be leveraged: law enforcement, web based-learning, telemedicine, grants to build positions/coalitions, etc.

5. MENTAL HEALTH PREVENTION

The impact of mental health to the individual, the family, and the community is debilitating. Prevention programs cost less and contribute to the overall health of the individual, the family, and the community. Among the barriers identified are: absence or minimal socialization activities in the refugee communities, unorganized groups, lack of leadership structure, inability to adjust.

Recommendations from focus groups include:

- identifying community/peer leaders;
- conduct community-based prevention program such as MHFA;
- providing support for community mental health prevention activities such as sewing, gardening, peer support;
- providing structured information sessions such as working with law enforcement and correctional officers;
- community integration through participation in cultural festival, cultural awareness training for refugee leaders and those helping them (direct support professionals, volunteers, etc)

6. INFORMATION DISSEMINATION

People can work together if they are well informed and if there is a clear instruction and coordinated action towards a common goal. The use of internet and social media are cheap and effective tools with wider reach. The challenge is how to get the information to providers, direct support professionals, volunteer groups, refugee communities, and support partners.

The group recommended for group email, periodic publication of resource guides, web links, regional newsletter/announcement, media snippet of refugee success in VA, include refugee update in All-in newsletter, and publish in webpage, list serve, and enhance council strategies to build awareness in local communities.

A panel discussion was set up so participants can hear the views of the refugee community with regards to mental health and how culture impacts refugee adjustment. The panelists and the country they came from include: Abubaker Abdelrahman (Sudan), Om Adhikari (Bhutan), Ibrahim Maroof (Afghanistan), and Bahar Kazimi (Afghanistan, representing women's view).

Cultural norms of the United States can often be traumatic for individuals and families. This can include the way of dress, making conjugal decisions, women making decisions, a shift in family dynamics, school and day care arrangements, going to the grocery store, and much more.

Overall, the panelist's general view on mental health, as viewed through their home country's cultural beliefs and practices, were:

- *Mental health is laden with stigma for the individual and the family*. In paternalistic societies, the head of household makes all the decisions, including what to do with a family member who may have mental health issues.
- *Mental health varies in severity*. The more severe it is, the more it negatively impacts the individual or his/her family. Family support is "automatic" and expected in countries represented by the panelists.
- *Economic hardship prevails over mental health treatment and care.* Panelists from Sudan and Afghanistan expressed views that there are not enough mental health providers (doctors and counselors) to cover all parts of the country. Most providers are in the urban areas making the treatment very expensive. In Sudan, families are poor and between food and mental health care, food comes first. The panelist from Bhutan stated that refugees from Bhutan who lived in Nepal refugee camps for over 18 years have limited access to

health and mental health care. All three countries represented use family support whenever possible.

- *Various cultures have different ways of dealing with everyday life*. Learning to live a new lifestyle, especially that which is opposite of what one knows, is extremely hard. Being in the United States, refugees have to adjust to the American way of life to integrate and resettle successfully. However, learning is a process and it takes time. Expecting refugees to live the American way in an unrealistic timeframe creates stress and can trigger traumatic experiences to surface.

Conclusion

These recommendations form the basis for action for the partnership moving forward. In FY17, the Partnership, co-sponsored by Fredericksburg Refugee Mental Health Council and Mary Washington Healthcare, will be holding a focus group session to identify and address issues related to refugees' access to health and mental health care. This event is organized in response to the request of behavioral health providers who believed that there is something they can do but did not have enough time to process and address the issues during the 2nd Refugee Mental Health Summit.

Summit participants identified mental health interpreter capacity as a critical challenge for services. As an additional way of improving language access for refugees and thus increasing access and quality service provision, the Partnership will offer the Mental Health interpreter Training in 2016. The training will be offered to professional medical interpreters only. This is a nationally recognized training that is a joint project between the National Latino Behavioral Health Association (NLBHA) and the National Asian American Pacific Islander Mental Health Association (NAAPIMHA). Its purpose is to improve service provision in by increasing an organization's ability to provide culturally and linguistically appropriate care.

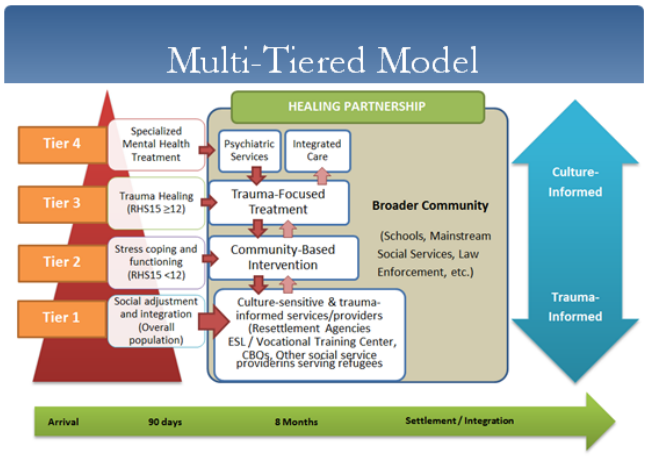

Figure: Multi-Tiered Refugee Mental Health Care Model (Im, 2014)

Another project related to the recommendations from the summit is the development of the Trauma Informed Cultural Orientation. This orientation for new arrivals offered to resettlement agencies will entail basic psycho-education for early detection and prevention of mental health issues and promotion of healthy adjustment. Refugee leaders that have been involved in earlier facilitator and peer trainings will be involved in providing training or peer support during the course of these orientations. These will be either agency- and/or community-based and will be aligned with Tier 1 (agency-based and trauma-informed and culture-informed services for overall population) as well as Tier 2. These activities are based on the Multi-tiered Refugee Mental Health Model from which the Partnership develops all interventions.

For questions or more information email oclc@dbhds.virginia.gov